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Gender Bias in Medicine

WIM, CME, LGBTQ Standing Committees

Neha Siddiqui, Avani Patel, Rishi Goel, Russyan Mark Mabeza, Imaima Casubhoy, Laura Barrera

Christina Chapman, MD

- Dr. Chapman is from Mercerville, NJ and obtained her B.A. in Biomedical Engineering from the Johns Hopkins University, her M.D. from the University of Pennsylvania Perelman School of Medicine and a Master's in Health and Healthcare Research from the University of Michigan. After completing her residency in Radiation Oncology at the University of Michigan, she joined the faculty as a health equity and health services researcher focusing on diversity in medical education and equitable access to cancer care. Clinically, she treats veterans with head and neck and lung cancer at the VA Ann Arbor Healthcare System. Advancing social justice is her overarching, lifelong passion.

Examples of Gender Bias in Medicine



Roxanne Sukol MD MS RYT200

@RoxanneSukolMD

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Replying to @DrMStiegler @choo_ek and 9 others

1st time I applied to med sch the interviewer asked if I intended to have children. Yes of course I said. Well you can't be both a mom + doc he said. I found other work, but reapplied 14 yrs later, and gave birth to my 3rd baby in year 2.

6:24 PM - 6 Jun 2019



Mage of Micturition and Free Flow

@catjacarol01

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Replying to @catjacarol01 @DrMStiegler and 10 others

While observing a complicated case later that year, a visiting professor looked down my scrub top and declared me "genetically blessed". My attending did not come to my defense in that moment, nor approach me later to check on how I was doing. I still wear turtlenecks in the OR.

2:20 PM - 7 Jun 2019

Case #1: Individual and Interpersonal Bias

Female Attending: “Hello, I’m Dr. S, and I look forward to working with you in clinic today. But first, I must address something.”

Female Resident: “Hello, I’m resident physician P. It’s nice to meet you. Of course, is there something wrong?”

Female Attending: “What are you wearing?”

Female Resident: *looks confused* Internal thoughts: “What could she be talking about? I’m dressed appropriately. Nothing is too tight. Everything is covered. My makeup is neutral.”

Female Attending: “Look, I am just trying to help you. This is a hospital, not a fashion show. I know you’ve complied with all of the rules regarding attire, but no one is going to take you seriously if you dress fashionable and wear makeup. It’s hard enough for women to work in a male-dominated world. It would be a shame for your colleagues and patients to not take you seriously. At least you didn’t wear your natural hair today.”

Case #1: Individual and Interpersonal Bias

Dr. P walks into the room and the patient complements how fashionable the resident is looking. “It’s nice to see that someone’s putting effort into the way they dress. Must mean you’re putting a lot of work into providing me the best care.” Patient chuckles.

Resident performance is flustered and thinks that she’s not as good of a doctor because her patient doesn’t take her seriously because of the way she dresses.

Because the resident was thrown off, a 10-minute annual exam turned into a 20-minute history and rushed physical exam. Patient appreciates how much time the resident gave her. Must be her “maternal instincts.” As resident leaves the room, patient asks her where she got her weave.

Resident gives disorganized patient presentation to attending.

During the lunch hour before afternoon clinic started, the resident physician felt devastated about how she was stereotyped and switched her footwear to flats, removed her makeup, and tied her hair in a ponytail. She removed her contact lenses which she usually wears on a daily basis and put on glasses to aid in her goal of looking older and worthy of “looking like” a physician. She also buttoned up her white coat all the way to hide her attire (and her personality).

Discussion Questions (Pick 2-3)

1. How should the resident physician handle this situation?
2. Should the attending physician have even addressed her concerns, and if so, is there a better way for the attending physician to handle her concerns?
3. How is this situation be different with the patient rather than an attending expressing this?
4. How should the resident physician react to the patients last comment? Should the resident physician address her concerns to an attending about the patients comment?
5. If the resident physician had a tattoo that couldn't be covered, how would she have been stereotyped differently? How should a person dress to be taken seriously as a physician?
6. How can one point out unconscious biases to superiors without coming across as stand-offish or disrespectful?
7. How might it further complication/simplify this situation if the attending was male?
8. If the resident physician complies with hospital attire guidelines, should he or she be reprimanded for personal style?
9. What are some long term considerations of someone internalizing this feedback of being "unprofessional"? How is this different than feedback on one's performance? How might this incident affect the resident's performance?
10. How might a bystander intervene - comments a senior resident can make to prevent this internalization or discrimination of subjective policies?

Unconscious/implicit biases: stereotypes or associations outside of conscious awareness that may lead to a negative evaluation of a person on the basis of irrelevant characteristics.

Inequities: differences that are systemic, avoidable, and unjust, arising from unconscious biases

Micro-inequities: small events that are often ephemeral, hard to prove, covert, unintentional, frequently unrecognized by the perpetrator.

Microaggressions: brief and commonplace verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative attitudes toward minority group.

How can leaders/colleagues advocate against gender bias?



HeForShe
UN Women Solidarity Movement
for Gender Equality

Cumulative micro-affirmations have the potential to foster individual and collective growth and allow everyone to thrive. Examples of micro-affirmations include:

- Appreciative inquiry: “What is something you are working on that you are excited about?”
- Recognition and validation of experiences and feelings: “I know that not getting the grant is a disappointment or having a patient complication is challenging.”
- Reinforcing and rewarding positive behaviors: “Congratulations on your publication!” Departments can develop academic incentive plans to reward faculty members for teaching, administrative, and research productivity.
- Intentional inclusion in professional settings (meetings, conferences, presentations) and information networks: “There is an upcoming prestigious meeting that I think you should attend. I’ll forward your name to the organizers.”
- Introducing team members by name and role: “This is Dr. _____, a resident working on your care team.”
- Diverse representation in public spaces: departments or institutions can ensure that portraits of successful women and people of color are displayed in meeting spaces.

In addition, critical actors—individuals who lead workplace culture transformation through role modeling and encouraging others to advance gender equity—are pivotal to spreading and sustaining micro-affirmations. Women in leadership roles help facilitate this process

Case #2: Institutional Bias

John and his twin sister Karen started off together as freshmen at their state university. They grew up in a rural town in their state, raised by their mother who was a nurse at the only primary care clinic in town, but had no physician family members. They both developed an interest in medicine and decided to apply for laboratory positions in the second semester of their freshman year.

They worked on their resumes together, and, after submitting separately to different labs, John received an email inviting him to interview for one of the most coveted laboratory positions for undergraduate students. Karen did not hear back from any laboratories and sent a few additional follow-up emails, but she received no responses.

Case #2: Institutional Bias

After initially failing to obtain a laboratory position, Karen decides that she should seek out advice and mentorship. Knowing that persistence is important, she composed an email to one of her professors in which she asks whether she could arrange a meeting to discuss strategies for success, including obtaining laboratory positions and making the most of her experience. Again, she received no response.

John began his time in the laboratory, learning new and interesting techniques, whereas Karen thought that she had better try again after improving her GPA for a semester, despite the fact that she did very well and had a GPA that was slightly higher than John's. Karen ultimately reapplied and secured a position in a good (but not excellent) laboratory during her sophomore year.

By the end of their junior year, John and Karen both decided that they had enjoyed their time in the laboratory and retained a passion for medicine, and both decided to apply to combined MD/PhD programs.

Case #2: Institutional Bias

As a result of having more experience in the laboratory, and achieving a position in a high profile laboratory that had an excellent track record of mentoring undergraduate students, John applied with a number of middle author and two first author publications, along with a letter of reference from a well-regarded scientist who said John reminded him of a younger version of himself. Not surprisingly, John received a number of MD/PhD interviews at exceptional programs.

Given her excellent GPA and MCAT score, Karen received a number of MD-only interviews at highly ranked medical schools, but no MD/PhD interviews. The following fall, John matriculated into an MD/PhD program, where he went on to achieve great success both in the laboratory and on his clinical rotations. Karen matriculated into an MD program and achieved great success clinically.

<https://doi.org/10.1016/j.ijrobp.2017.04.015>

Case #2: Institutional Bias

At this year's Thanksgiving dinner, 10 years after Karen graduated from medical school, she recounts to her mom her difficulties in academic medicine. Although she received a tenure extension for her maternity leave, she still has not been able to produce enough publications to be considered for tenure.

Case Discussion Questions (pick 3)

1. What barriers did Karen encounter in the process of applying to medical schools?
2. What assumptions and societal expectations may be salient in Dr. S's career pursuit and family planning?
3. How might the current gender makeup of the committee have influenced the votes?
4. What changes could make consideration for leadership exclusively based on qualifications?
5. How might someone else on the committee attest to Dr. S's capabilities?
6. Residents often complain about female-dominated specialties because there are times that other residents may have to cover when residents take leave for childcare reasons. How might a program more fairly accommodate all parties?
7. How can leaders or colleagues in medicine advocate for women in medicine?

Phases and Levels of Institutional Bias

Definition: Structures and policies that generate inequity

- To get a certain tenure position, you must have X years of uninterrupted experience
- A board is made up of mostly men, who may not understand diverse perspectives or experiences
- Certain hours are not conducive to all populations (eg, late afternoon research meetings) which affords individuals with specific responsibilities (eg, no caregiver duties, shorter commutes, etc.) more opportunities
- Research is dependent on mentorship; grants dependent on prior grants; perpetuates the systematic exclusion of populations

Cumulative disadvantage theory and the accumulation of advantage: operating at a systemic minute disadvantage can have substantial long-term effects

A Computer Simulation

Martell, Lane & Emrich (1996) on the Accumulation of Bias:

- *Assumed a tiny bias in favor of men*
- *Only 1% of variance in promotion was accounted by this*
- *Many iterations... top level was 65% male*
- Similar to the idea of biomagnification.



Some Facts about Gender Bias

- Despite being over half the workforce, 32% of associate professors at medical schools are women, 20% of full professors are women, 14% of department chairs are women, and 11% of deans of medical schools are women.
- Women physicians are less likely to be introduced by their title.
- Women physicians are more likely to experience burnout.
- 50% of female medical students experience sexual harassment before they graduate.
- Female trainees are more likely to be first author on a paper when their PI is a female.
- Pervades to research: women were not included in most clinical trials until the mid 2000s.
- Even after adjustment for work hours, specialty, academic rank, leadership positions, publications, and research time - men still make more than women physicians.
- 2/3rd of the women surgery residents reporting gender discrimination and 1/5th reporting sexual harassment

Gender-based Aggression Starts Early

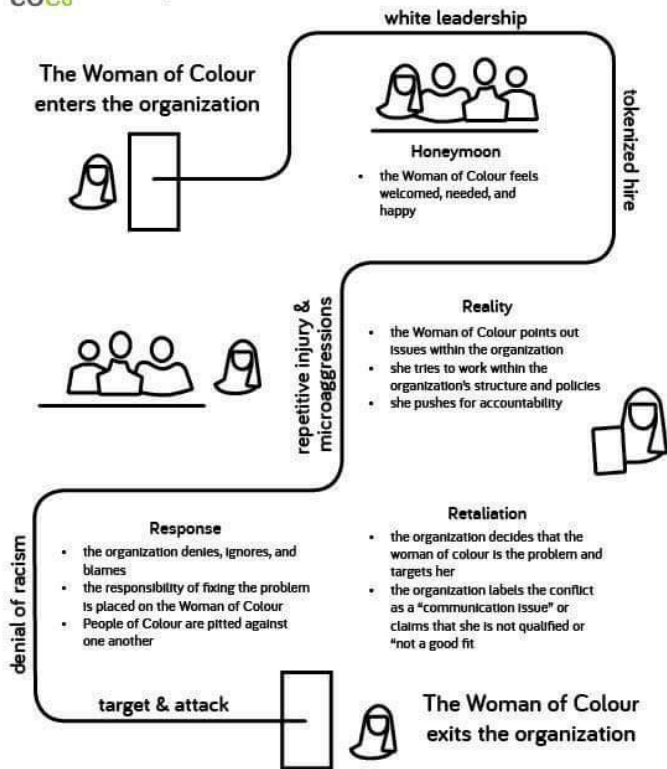
- encountering sexism
- encountering pregnancy- and childcare-related bias
- having abilities underestimated
- encountering sexually inappropriate comments
- being relegated to mundane tasks
- feeling excluded/marginalized
- gender blindness in research

Intersectionality

- Gender expression (androgynous dressing)
- Race or ethnicity (“natural” hair)
- Socioeconomic status
- Religion (head scarf)



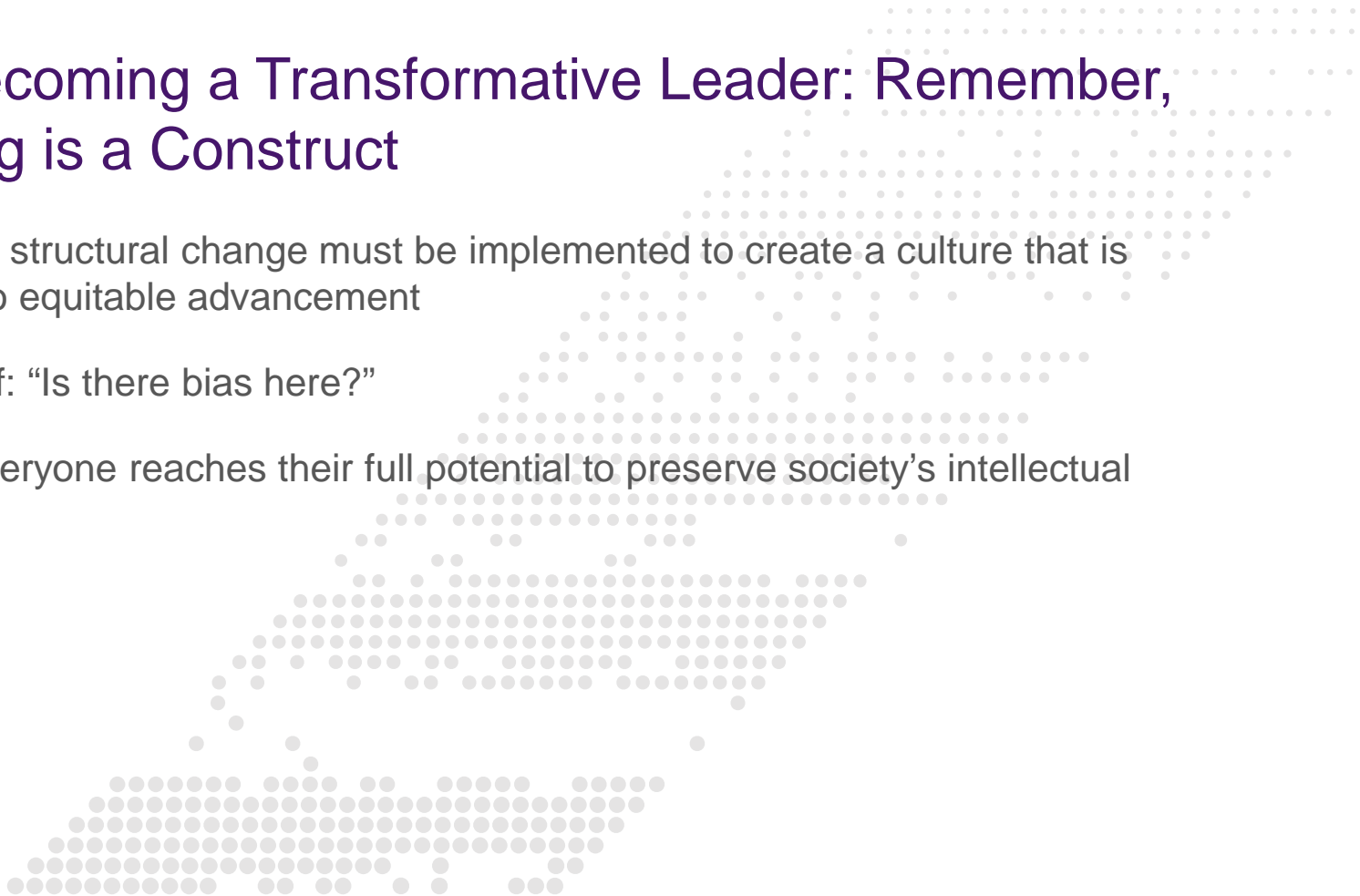
The “Problem” Woman of Colour in the Workplace



Adapted from "The Chronicle of the Problem Woman of Color in a Non-Profit" by the Safehouse Progressive Alliance for Nonviolence
www.coco-net.org

Key to Becoming a Transformative Leader: Remember, Everything is a Construct

- Deliberative structural change must be implemented to create a culture that is facilitative to equitable advancement
- Ask yourself: “Is there bias here?”
- Ensuring everyone reaches their full potential to preserve society’s intellectual capital





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